General

Guideline Title

Management of epithelial ovarian cancer. A national clinical guideline.

Bibliographic Source(s)

Scottish Intercollegiate Guidelines Network (SIGN). Management of epithelial ovarian cancer. A national clinical guideline. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network (SIGN); 2013 Nov. 59 p. (SIGN publication; no. 135). [219 references]

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Scottish Intercollegiate Guidelines Network (SIGN). Epithelial ovarian cancer. A national clinical guideline. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network (SIGN); 2003 Oct. 36 p. (SIGN publication; no. 75). [182 references]

Any amendments to the guideline in the interim period will be noted on the Scottish Intercollegiate Guidelines Network (SIGN) Web site .

Recommendations

Major Recommendations

Note from the Scottish Intercollegiate Guidelines Network (SIGN) and National Guideline Clearinghouse (NGC): In addition to these evidence-based recommendations, the guideline development group also identifies points of best clinical practice in the full-text guideline document.

The grades of recommendation (A-D) and levels of evidence (1++, 1+, 1-, 2++, 2+, 2-, 3, 4) are defined at the end of the "Major Recommendations" field.

Screening and the Role of Prophylactic Salpingo-Oophorectomy

Screening for Ovarian Cancer in the General Population

A - Screening for ovarian cancer in the general population should not be performed outwith the research setting.

Identifying Women at High Risk of Developing Ovarian Cancer

Defining High Risk Groups Using Genetic Testing

D - All women with non-mucinous ovarian or fallopian tube cancer should be offered *BRCA1* and *BRCA2* mutation testing.

D - Women with ovarian cancer who have a family history of breast, ovarian or colon cancer should have a genetic risk assessment.

D - *BRCA1* and *BRCA2* mutation analysis should be considered in a family where there is a 10% or greater risk of a mutation being present.

Screening High Risk Groups

D - Screening for ovarian cancer in high risk groups should only be offered in the context of a research study.

Prophylactic Salpingo-Oophorectomy

C - Women with genetic mutations of *BRCA1* or *BRCA2* genes should be offered prophylactic oophorectomy and removal of fallopian tubes at a relevant time in their life.

Diagnosis

Primary Care

Signs and Symptoms

C - In women presenting in general practice with one or more symptoms of abdominal distension or bloating with or without abdominal pain, feeling full quickly, difficulty eating, or urinary symptoms, of less than 12 months duration and occurring more than 12 times per month a diagnosis of ovarian cancer should be considered.

Investigations in Primary Care

D - CA125 blood serum level should be measured and urgent pelvic ultrasound carried out in women with persistent abdominal distension or feeling full and/or loss of appetite or pelvic or abdominal pain or increased urinary urgency and/or frequency (particularly if occurring more than 12 times per month and especially if she is over 50).

D - If symptoms persist or worsen despite a normal CA125 blood serum level and a negative ultrasound scan, refer to secondary care.

Secondary Care

Risk of Malignancy Index (RMI)

B - RMI 1 score with threshold of 200 should be used to predict the likelihood of ovarian cancer. Patients with an RMI 1 score greater than 200 should be referred to a gynaecology-oncology multidisciplinary team.

Further Radiological Imaging

B - Computed tomography (CT) of the abdomen and pelvis should be performed in secondary care for all patients suspected of having ovarian cancer who have an RMI score greater than 200.

D - Magnetic resonance imaging (MRI) is not recommended for routine staging of ovarian cancer.

D - Positron emission tomography-computed tomography (PET-CT) is not recommended in the diagnosis or initial staging of ovarian cancer.

The Role of the Clinical Nurse Specialist

D - Patients should be given their diagnosis of ovarian cancer in the presence of a clinical nurse specialist who is a fully integrated member of the gynaecological cancer team.

D - Throughout their care pathway patients with ovarian cancer should have access to a clinical nurse specialist who should be an integral member of the gynaecological cancer team.

Surgical Management

Pathology

Intraoperative Techniques

B - To minimise the need for a second operative staging procedure, intraoperative frozen section assessment can be used to diagnose malignancy

and to exclude metastatic disease.

Management of Early Disease

Systematic Retroperitoneal Lymphadenectomy

C - Routine systematic lymphadenectomy in early stage epithelial ovarian cancer is not recommended.

The Role of Retroperitoneal Lymph Node Sampling

C - Retroperitoneal lymph node sampling should be considered as part of surgical staging for apparent early stage disease.

Fertility Conserving Surgery

D - In women with stage Ia, grade 1 or grade 2 disease, fertility conserving surgery is an option as long as the contralateral ovary appears normal and there is no evidence of omental or peritoneal disease. Optimal surgical staging should be done and should include biopsies of suspicious looking peritoneal nodules, infracolic omentectomy, and iliac and peri-aortic lymph node sampling.

Optimal Surgery for Advanced Disease

Cytoreductive Surgery

C - In surgery for advanced ovarian cancer, the aim should be to achieve complete cytoreduction.

Neoadjuvant Chemotherapy and Delayed Primary Surgery

A - The use of neoadjuvant chemotherapy in women with stage IIIc or IV ovarian cancer may be considered as an alternative to primary debulking surgery.

Relapsed Disease

C - In selected patients with relapsed epithelial ovarian cancer which is platinum-sensitive, secondary cytoreductive surgery may be appropriate and may improve overall survival. The aim should be complete resection of all macroscopic disease. Where possible, this should be done in the context of a clinical trial.

Chemotherapy

Early Disease

Adjuvant Chemotherapy for Stage IA and Stage 1B Disease

B - All women with high-grade early stage (Ia-Ib) ovarian cancer should be considered for adjuvant chemotherapy.

Maintenance Therapy in Early Stage Disease

B - For early stage disease, maintenance cytotoxic chemotherapy should not be given.

Advanced Disease

Role of Platinum Agents

A - First line chemotherapy treatment of epithelial ovarian cancer should include a platinum agent either in combination or as a single agent, unless specifically contraindicated.

Choice of Platinum Agents

A - Carboplatin is the platinum drug of choice in both single and combination therapy.

Other Agents

A - Paclitaxel is recommended in combination therapy with platinum in the first line post-surgery treatment of epithelial ovarian cancer where the potential benefits justify the toxicity of the therapy. In those unable to tolerate paclitaxel, pegylated liposomal doxorubicin or gemcitabine in combination with carboplatin can be used as an alternative.

A - Patients who are unfit for combination therapy should be offered single agent carboplatin.

A - A third cytotoxic agent should not be added to carboplatin and paclitaxel.

Scheduling

B - Carboplatin area under the curve (AUC) 6 (day 1 q21 [every 21 days]) and paclitaxel 80 mg/m^2 (day 1, 8, 15 q21) may be considered for the treatment of first line ovarian cancer. The increased toxicity and frequency of visits need to be discussed with the patient.

Maintenance Therapies

A - For advanced ovarian cancer, maintenance cytotoxic chemotherapy should not be given following standard first line chemotherapy.

Intraperitoneal Chemotherapy

B - Chemotherapy which includes an intraperitoneal element can be considered for women with a new diagnosis of epithelial ovarian cancer and residual disease of ≤1 cm after primary surgery provided a regimen of proven benefit in a clinical trial compared to intravenous therapy is used, it is delivered in a centre with appropriate expertise and the potential toxicities are fully explained.

Relapsed Disease

Systemic Therapy in Recurrent Ovarian Cancer

A - Women with platinum-sensitive relapsed ovarian cancer should be treated with a platinum based combination with paclitaxel, pegylated liposomal doxorubicin hydrochloride (PLDH) or gemcitabine.

The Role of Hormonal Therapy in Relapsed Disease

D - Hormonal therapy with tamoxifen or an aromatase inhibitor can be used for women with recurrent, platinum-resistant, ovarian cancer or in those wishing to avoid or delay further chemotherapy, particularly where their original tumour is expressing the oestrogen receptor.

Follow Up

A - Treatment of first relapse of ovarian cancer should be guided by the development of symptoms.

A - In the absence of symptoms, routine measurement of CA125 during follow up is not mandatory.

Management of Malignant Bowel Obstruction in Relapsed Disease

Surgical Management

C - Surgery for malignant bowel obstruction in patients with advanced ovarian cancer must be justified on the basis of achieving a significant benefit.

Non-Surgical Management

Pain, Nausea and Vomiting

C - Symptoms of bowel obstruction can be relieved by using the following drug categories either alone or in combination:

- Antiemetic
- Antisecretory
- Analgesic
- Corticosteroids

Definitions:

Levels of Evidence

1++: High quality meta-analyses, systematic reviews of randomised controlled trials (RCTs), or RCTs with a very low risk of bias

1+: Well-conducted meta-analyses, systematic reviews, or RCTs with a low risk of bias

1-: Meta-analyses, systematic reviews, or RCTs with a high risk of bias

2++: High quality systematic reviews of case control or cohort studies

High quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal

2+: Well conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal

2-: Case control or cohort studies with a high risk of confounding or bias and a significant risk that the relationship is not causal

3: Non-analytic studies, (e.g., case reports, case series)

4: Expert opinion

Grades of Recommendation

A: At least one meta-analysis, systematic review or randomised controlled trial (RCTs), rated as 1++ and directly applicable to the target population; or

A body of evidence consisting principally of studies rated as 1+, directly applicable to the target population, and demonstrating overall consistency of results

B: A body of evidence including studies rated as 2++, directly applicable to the target population, and demonstrating overall consistency of results; or

Extrapolated evidence from studies rated as 1++ or 1+

C: A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results; or

Extrapolated evidence from studies rated as 2++

D: Evidence level 3 or 4; or

Extrapolated evidence from studies rated as 2+

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Epithelial ovarian cancer

Guideline Category

Diagnosis

Management

Risk Assessment

Screening

Treatment

Clinical Specialty

Colon and Rectal Surgery

Family Practice

Internal Medicine

Medical Genetics

Nursing

Obstetrics and Gynecology

Oncology

Pathology

Radiology

Surgery

Intended Users

Advanced Practice Nurses

Allied Health Personnel

Clinical Laboratory Personnel

Nurses

Pharmacists

Physician Assistants

Physicians

Guideline Objective(s)

To provide recommendations based on current evidence for best practice in the management of epithelial ovarian cancer

Note: The management of borderline tumours is not included within these recommendations.

Target Population

- Women with epithelial ovarian cancer
- Women identified as being at high risk of ovarian cancer

Interventions and Practices Considered

Screening

1. *BRCA1* and *BRCA2* mutation testing
2. Screening for high risk groups in the context of a research study only
3. Prophylactic salpingo-oophorectomy
4. Genetic risk assessment

Diagnosis

Primary Care

1. Evaluation of signs and symptoms

2. CA125 blood serum level measurement
3. Ultrasound

Secondary Care

1. Referred to a gynaecology-oncology multidisciplinary team
2. Risk of Malignancy Index (RMI)
3. Computed tomography (CT)
4. Access to clinical nurse specialist

Note: The following interventions were considered but not recommended:

Magnetic resonance imaging (MRI)
Positron emission tomography-computed tomography (PET-CT)

Management

Surgical

1. Intraoperative frozen section assessment
2. Retroperitoneal lymph node sampling as part of surgical staging for early stage disease
3. Fertility conserving surgery
4. Primary cytoreductive surgery
5. Consideration of neoadjuvant chemotherapy as an alternative to primary debulking surgery
6. Secondary cytoreductive surgery for relapsed disease

Chemotherapy

1. Adjuvant chemotherapy in early stage disease
2. Platinum agent (carboplatin)
3. Other agents (paclitaxel, pegylated liposomal doxorubicin or gemcitabine in combination with carboplatin)
4. Intraperitoneal chemotherapy
5. Platinum based combination with paclitaxel, pegylated doxorubicin hydrochloride (PLDH) or gemcitabine
6. Hormonal therapy (tamoxifen or an aromatase inhibitor)

Management of Malignant Bowel Obstruction in Relapsed Disease

Surgical management
Non-surgical management:

- Corticosteroids
- Antiemetics
- Antisecretory
- Analgesics

Major Outcomes Considered

- Accuracy of diagnostic tests
- Overall survival rates
- Response rates
- Progression-free survival rates
- Disease-free survival rates
- Quality of life
- Adverse effects of treatment (e.g., toxicity)

Methodology

Methods Used to Collect/Select the Evidence

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Systematic Literature Review

The evidence base for this guideline was synthesised in accordance with Scottish Intercollegiate Guidelines Network (SIGN) methodology. A systematic review of the literature was carried out using an explicit search strategy devised by a SIGN Evidence and Information Scientist. Databases searched include MEDLINE, EMBASE, CINAHL, PsycINFO and the Cochrane Library. The year range covered was 2003 to 2012. Internet searches were carried out on various websites including the US National Guideline Clearinghouse (NGC). The main searches were supplemented by material identified by individual members of the development group. Each of the selected papers was evaluated by two members of the group using standard SIGN methodological checklists before conclusions were considered as evidence.

Literature Search for Patient Issues

At the start of the guideline development process, a SIGN Evidence and Information Scientist conducted a literature search for qualitative and quantitative studies that addressed patient issues of relevance to early management of patients with epithelial ovarian cancer. Databases searched include MEDLINE, EMBASE, CINAHL, and PsycINFO, and the results were summarised and presented to the guideline development group.

Number of Source Documents

Not stated

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Levels of Evidence

1++: High quality meta-analyses, systematic reviews of randomised controlled trials (RCTs), or RCTs with a very low risk of bias

1+: Well-conducted meta-analyses, systematic reviews, or RCTs with a low risk of bias

1-: Meta-analyses, systematic reviews, or RCTs with a high risk of bias

2++: High quality systematic reviews of case control or cohort studies

High quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal

2+: Well conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal

2-: Case control or cohort studies with a high risk of confounding or bias and a significant risk that the relationship is not causal

3: Non-analytic studies, (e.g., case reports, case series)

4: Expert opinion

Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

Once papers have been selected as potential sources of evidence, the methodology used in each study is assessed to ensure its validity. The result of this assessment will affect the level of evidence allocated to the paper, which will in turn influence the grade of recommendation that it supports.

The methodological assessment is based on a number of key questions that focus on those aspects of the study design that research has shown to have a significant influence on the validity of the results reported and conclusions drawn. These key questions differ between study types, and a range of checklists is used to bring a degree of consistency to the assessment process. Scottish Intercollegiate Guidelines Network (SIGN) has based its assessments on the MERGE (Method for Evaluating Research and Guideline Evidence) checklists developed by the New South Wales Department of Health, which have been subjected to wide consultation and evaluation. These checklists were subjected to detailed evaluation and adaptation to meet SIGN's requirements for a balance between methodological rigour and practicality of use.

The assessment process inevitably involves a degree of subjective judgment. The extent to which a study meets a particular criterion - e.g., an acceptable level of loss to follow up - and, more importantly, the likely impact of this on the reported results from the study will depend on the clinical context. To minimise any potential bias resulting from this, each study must be evaluated independently by at least two group members. Any differences in assessment should then be discussed by the full group. Where differences cannot be resolved, an independent reviewer or an experienced member of SIGN Executive staff will arbitrate to reach an agreed quality assessment.

Evidence Tables

Evidence tables are compiled by SIGN executive staff based on the quality assessments of individual studies provided by guideline development group members. The tables summarise all the validated studies identified from the systematic literature review relating to each key question. They are presented in a standard format to make it easier to compare results across studies, and will present separately the evidence for each outcome measure used in the published studies. These evidence tables form an essential part of the guideline development record and ensure that the basis of the guideline development group's recommendations is transparent.

Additional details can be found in the companion document titled "SIGN 50: A Guideline Developers' Handbook." (Edinburgh [Scotland]: Scottish Intercollegiate Guidelines Network. [SIGN publication; no. 50]), available from the SIGN Web site .

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

Synthesising the Evidence

Guideline recommendations are graded to differentiate between those based on strong evidence and those based on weak evidence. This judgement is made on the basis of an (objective) assessment of the design and quality of each study and a (perhaps more subjective) judgement on the consistency, clinical relevance and external validity of the whole body of evidence. The aim is to produce a recommendation that is evidence-based, but which is relevant to the way in which health care is delivered in Scotland and is therefore implementable.

It is important to emphasise that the grading does not relate to the importance of the recommendation, but to the strength of the supporting evidence and, in particular, to the predictive power of the study designs from which that data was obtained. Thus, the grading assigned to a recommendation indicates to users the likelihood that, if that recommendation is implemented, the predicted outcome will be achieved.

Considered Judgement

It is rare for the evidence to show clearly and unambiguously what course of action should be recommended for any given question. Consequently, it is not always clear to those who were not involved in the decision making process how guideline developers were able to arrive at their recommendations, given the evidence they had to base them on. In order to address this problem, Scottish Intercollegiate Guidelines Network (SIGN) has introduced the concept of considered judgement.

Under the heading of considered judgement, guideline development groups summarise their view of the total body of evidence covered by each evidence table.

Each guideline group considers the following factors:

- Quantity, quality, and consistency of evidence
- External validity (generalisability) of studies
- Directness of application to the target population for the guideline
- Any evidence of potential harms associated with implementation of a recommendation
- Clinical impact (i.e., the extent of the impact on the target patient population, and the resources needed to treat them in accordance with the recommendation)
- Whether, and to what extent, any equality groups may be particularly advantaged or disadvantaged by the recommendations made
- Implementability (i.e., how practical it would be for the National Health Service [NHS] Scotland to implement the recommendation.)

Then the group is asked to summarise its view on all of these issues, both the quality of the evidence and its potential impact, before making a graded recommendation. This summary should be succinct, and taken together with its views of the level of evidence represent the first draft of the text that will appear in the guideline immediately before a graded recommendation.

Additional detail about SIGN's process for formulating guideline recommendations is provided in Section 7 of the companion document titled "SIGN 50: A Guideline Developers' Handbook." (Edinburgh [Scotland]: Scottish Intercollegiate Guidelines Network. [SIGN publication; no. 50]), available from the SIGN Web site .

Rating Scheme for the Strength of the Recommendations

Grades of Recommendation

Note: The grade of recommendation relates to the strength of the evidence on which the recommendation is based. It does not reflect the clinical importance of the recommendation.

A: At least one meta-analysis, systematic review, or randomised controlled trial (RCT) rated as 1++ and directly applicable to the target population; or

A body of evidence consisting principally of studies rated as 1+, directly applicable to the target population, and demonstrating overall consistency of results

B: A body of evidence including studies rated as 2++, directly applicable to the target population, and demonstrating overall consistency of results; or

Extrapolated evidence from studies rated as 1++ or 1+

C: A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results; or

Extrapolated evidence from studies rated as 2++

D: Evidence level 3 or 4; or

Extrapolated evidence from studies rated as 2+

Cost Analysis

The guideline developers reviewed published cost analyses.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

The national open meeting is the main consultative phase of Scottish Intercollegiate Guidelines Network (SIGN) guideline development.

Peer Review

All SIGN guidelines are reviewed in draft form by independent expert referees, who are asked to comment primarily on the comprehensiveness and accuracy of interpretation of the evidence base supporting the recommendations in the guideline. A number of general practitioners (GPs) and other primary care practitioners also provide comments on the guideline from the primary care perspective, concentrating particularly on the clarity of the recommendations and their assessment of the usefulness of the guideline as a working tool for the primary care team. The draft is also sent to at least two lay reviewers in order to obtain comments from the patient's perspective.

It should be noted that all reviewers are invited to comment as individuals, not as representatives of any particular organisation or group. Corporate interests, whether commercial, professional, or societal have an opportunity to make representations at the national meeting stage where they can send representatives to the meeting or provide comment on the draft produced for that meeting. Peer reviewers are asked to complete a declaration of interests form.

The comments received from peer reviewers and others are carefully tabulated and discussed with the Chair and with the guideline development group. Each point must be addressed and any changes to the guideline as a result noted or, if no change is made, the reasons for this recorded.

As a final quality control check prior to publication, the guideline and the summary of peer reviewers' comments are reviewed by the SIGN Editorial Group for that guideline to ensure that each point has been addressed adequately and that any risk of bias in the guideline development process as a whole has been minimised. Each member of the guideline development group is then asked formally to approve the final guideline for publication.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for each recommendation (see the "Major Recommendations" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Appropriate screening, diagnosis and management of women at high risk for or with epithelial ovarian cancer

Potential Harms

- Surgical complications:
  - Haemorrhage
  - Venous thromboembolism
  - Infection
- Adverse effects associated with chemotherapy, including:
  - Anaemia
  - Thrombocytopenia
  - Neuropathy
  - Grade 2 alopecia
  - Diarrhoea
  - Stomatitis
  - Skin toxicity

Contraindications

Contraindications

Contraindications to Surgery for Malignant Bowel Obstruction in Patients with Advanced Ovarian Cancer

Absolute contraindications:

- Patient refusal
- Previous abdominal surgery which showed diffuse metastatic cancer
- Involvement of proximal stomach
- Intra-abdominal carcinomatosis demonstrated radiologically with a contrast study revealing a severe motility problem
- Diffuse palpable intra-abdominal masses (having excluded faecal masses)
- Massive ascites which rapidly recurs after drainage

Relative contraindications:

- Non-symptomatic extensive extra-abdominal malignant disease (e.g., widespread metastases and pleural effusion)
- Poor general performance status
- Poor nutritional status (e.g., marked weight loss/cachexia, marked hypoalbuminaemia, and low lymphocyte count)
- Severe cachexia
- Small bowel obstruction
- Previous radiotherapy of the abdomen or pelvis

Qualifying Statements

Qualifying Statements

- This guideline is not intended to be construed or to serve as a standard of care. Standards of care are determined on the basis of all clinical data available for an individual case and are subject to change as scientific knowledge and technology advance and patterns of care evolve. Adherence to guideline recommendations will not ensure a successful outcome in every case, nor should they be construed as including all proper methods of care or excluding other acceptable methods of care aimed at the same results. The ultimate judgement must be made by the appropriate healthcare professional(s) responsible for clinical decisions regarding a particular clinical procedure or treatment plan. This judgement should only be arrived at following discussion of the options with the patient, covering the diagnostic and treatment choices available. It is, however, advised that significant departures from the national guideline or any local guidelines derived from it should be fully documented in the patient's case notes at the time the relevant decision is taken.
- Recommendations within this guideline are based on the best clinical evidence. Some recommendations may be for medicines prescribed outwith the marketing authorisation (MA) also known as product licence. This is known as 'off label' use.
  Medicines may be prescribed off label in the following circumstances:

  - For an indication not specified within the marketing authorization
  - For administration via a different route
  - For administration of a different dose
  - For a different patient population

  An unlicensed medicine is a medicine which does not have MA for medicinal use in humans.

  Generally the off label use of medicines becomes necessary if the clinical need cannot be met by licensed medicines within the marketing authorisation. Such use should be supported by appropriate evidence and experience.

  "Prescribing medicines outside the conditions of their marketing authorisation alters (and probably increases) the prescribers' professional responsibility and potential liability."

  The General Medical Council (GMC) recommends that when prescribing a medicine off-label, doctors should:

  - Be satisfied that such use would better serve the patient's needs than an authorised alternative (if one exists)
  - Be satisfied that there is sufficient evidence/experience of using the medicines to show its safety and efficacy, seeking the necessary information from appropriate sources.
  - Record in the patient's clinical notes the medicine prescribed and, when not following common practice, the reasons for the choice.

- Take responsibility for prescribing the medicine and for overseeing the patient's care, including monitoring the effects of the medicine.

Non-medical prescribers should ensure that they are familiar with the legislative framework and their own professional prescribing standards.

Prior to any prescribing, the licensing status of a medication should be checked in the current version of the British National Formulary (BNF). The prescriber must be competent, operate within the professional code of ethics of their statutory body and the prescribing practices of their employer.

Implementation of the Guideline

Description of Implementation Strategy

Implementation of national clinical guidelines is the responsibility of each National Health System (NHS) Board and is an essential part of clinical governance. Mechanisms should be in place to review care provided against the guideline recommendations. The reasons for any differences should be assessed and addressed where appropriate. Local arrangements should then be made to implement the national guideline in individual hospitals, units and practices.

Refer to Section 10 in the original guideline for information on resource implications associated with implementing the key clinical recommendations and advice on audit as a tool to aid implementation.

Implementation Tools

Audit Criteria/Indicators

Mobile Device Resources

Quick Reference Guides/Physician Guides

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

Living with Illness

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

Scottish Intercollegiate Guidelines Network (SIGN). Management of epithelial ovarian cancer. A national clinical guideline. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network (SIGN); 2013 Nov. 59 p. (SIGN publication; no. 135). [219 references]

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2003 Oct (revised 2013 Nov)

Guideline Developer(s)

Scottish Intercollegiate Guidelines Network - National Government Agency [Non-U.S.]

Source(s) of Funding

Scottish Executive Health Department

Guideline Committee

Guideline Development Group

Composition of Group That Authored the Guideline

Guideline Development Group: Dr Nadeem Siddiqui (*Chair*), Consultant Gynaecologist and Oncologist, Glasgow Royal Infirmary; Ms Sandra Bredin, Clinical Nurse Specialist, Glasgow Royal Infirmary; Ms Beatrice Cant, Programme Manager, SIGN; Dr En Hsun Choi, Consultant Radiologist, Forth Valley Royal Hospital, Larbert; Dr Scott Fegan, Consultant Gynaecological Oncologist, Royal Infirmary of Edinburgh; Dr Michelle Ferguson, Consultant Medical Oncologist, Ninewells Hospital, Dundee; Dr Rosalind Glasspool, Consultant Medical Oncologist and Honorary Senior Lecturer, Beatson Oncology Centre, Glasgow; Professor Charlie Gourley, Professor and Honorary Consultant in Medical Oncology, Western General Hospital, Edinburgh; Dr Karen Gray, Consultant Radiologist, Crosshouse Hospital, Kilmarnock; Dr Rhona Lindsay, SpR, sub-specialty trainee, Department of Gynaecological Oncology, Glasgow Royal Infirmary; Ms Maureen Mackay, Patient Representative; Ms Dianna Manson, Patient Representative; Dr Zosia Miedzybrodzka, Reader in Medical Genetics, University of Aberdeen; Dr David Millan, Consultant Pathologist, Southern General Hospital, Glasgow; Dr David Parkin, Consultant Gynaecological Oncologist, Aberdeen Royal Infirmary; Dr Nicholas Reed, Clinical Oncologist, Gartnavel General Hospital, Glasgow; Ms Diane Stirling, Principal Genetic Counsellor, Western General Hospital, Edinburgh; Mrs Lynne Smith, Evidence and Information Scientist, SIGN; Dr Valerie Wareham, Consultant Gynaecologist, Raigmore Hospital, Inverness; Professor David Weller Head, School of Clinical Sciences and Community Health, General Practice Section, University of Edinburgh

Financial Disclosures/Conflicts of Interest

Declarations of interests were made by all members of the guideline development group. Further details are available from the Scottish Intercollegiate Guidelines Network (SIGN) Executive.

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Scottish Intercollegiate Guidelines Network (SIGN). Epithelial ovarian cancer. A national clinical guideline. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network (SIGN); 2003 Oct. 36 p. (SIGN publication; no. 75). [182

references]

Any amendments to the guideline in the interim period will be noted on the Scottish Intercollegiate Guidelines Network (SIGN) Web site .

Guideline Availability

Electronic copies: Available in Portable Document Format (PDF) from the Scottish Intercollegiate Guidelines Network (SIGN) Web site .

Availability of Companion Documents

The following are available:

- Quick reference guide: management of epithelial ovarian cancer. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network; 2013 Nov. 2 p. Electronic copies: Available in Portable Document Format (PDF) from the Scottish Intercollegiate Guidelines Network (SIGN) Web site .
- SIGN 50: A guideline developer's handbook. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network; 2011 Sep. 111 p. (SIGN publication; no. 50). Electronic copies: Available from the SIGN Web site .

In addition, Section 10 in the original guideline document contains key points to audit.

Executive summaries of SIGN guidelines are available for mobile devices through the guidelines app on the SIGN Web site .

Patient Resources

None available

NGC Status

This NGC summary was completed by ECRI on May 3, 2004. The information was verified by the guideline developer on July 15, 2004. This summary was updated by ECRI on January 29, 2007, following the U.S. Food and Drug Administration advisory on erythropoiesis stimulating agents. This summary was updated by ECRI Institute on June 22, 2007 following the U.S. Food and Drug Administration (FDA) advisory on heparin sodium injection. This summary was updated by ECRI Institute on July 9, 2007, following the FDA advisory on erythropoiesis stimulating agents. This summary was updated by ECRI Institute on March 13, 2008 following the updated FDA advisory on heparin sodium injection. This summary was updated by ECRI Institute on March 21, 2008 following the FDA advisory on Erythropoiesis Stimulating Agents. This summary was updated by ECRI Institute on August 15, 2008 following the U.S. Food and Drug Administration advisory on Erythropoiesis Stimulating Agents (ESAs). This summary was updated by ECRI Institute on December 26, 2008 following the FDA advisory on Innohep (tinzaparin). This summary was updated by ECRI Institute on January 7, 2009 following the FDA advisory on oral sodium phosphate (OSP) products for bowel cleansing. The information was reaffirmed by the guideline developer in 2007 and updated by ECRI Institute on March 29, 2010. This summary was updated by ECRI Institute on April 1, 2010 following the U.S. Food and Drug Administration advisory on Erythropoiesis-Stimulating Agents (ESAs). This summary was updated by ECRI Institute on July 27, 2010 following the FDA drug safety communication on Heparin. The currency of the guideline was reaffirmed by the developer in 2011 and this summary was updated by ECRI Institute on October 25, 2012. This summary was updated by ECRI Institute on January 3, 2014.

Copyright Statement

Additional copyright information is available on the SIGN Web site .

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